SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
Filing Company:	*The Baltimore Life Insurance Company*	*State Tracking Number:*	*48532*
Company Tracking Number:	*8232-0411*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY*		
Project Name/Number:	*APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY/8232-0411*		

Filing at a Glance

Company: The Baltimore Life Insurance Company

Product Name: APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY	SERFF Tr Num: BALT-127119823	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 48532
Sub-TOI: L08.000 Life - Other	Co Tr Num: 8232-0411	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Lesia Braddy	Disposition Date: 04/21/2011
	Date Submitted: 04/19/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY	Status of Filing in Domicile: Pending
Project Number: 8232-0411	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: The form is being filed concurrently in Maryland, our state of domicile.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 04/21/2011
	State Status Changed: 04/21/2011
Deemer Date:	Created By: Lesia Braddy
Submitted By: Lesia Braddy	Corresponding Filing Tracking Number: 8232-0411

Filing Description:

Attached is Form 8232-0411. This is a new form and will supersede Form 8232 which was approved by your Department on 10/14/09. The form has been revised as follows:

The medical questions have been expanded. Also questions designed to reasonably detect and prevent stranger

SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
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originated life insurance have been added

This form will continue to be used with form 8243(AR), which was approved by your department on 10/14/09.

We certify that this submission meets the provisions of Regulations 19, as well as all of the applicable requirements of the department.

Company and Contact

Filing Contact Information

Lesia Williams Braddy, Director Policy Forms Compliance	lesia.williams@baltlife.com
10075 Red Run Boulevard	800-628-5433 [Phone]
Owings Mills, MD 21117-4871	410-581-6605 [FAX]

Filing Company Information

The Baltimore Life Insurance Company	CoCode: 61212	State of Domicile: Maryland
10075 Red Run Boulevard	Group Code: 849	Company Type:
Owings Mills, MD 21117	Group Name:	State ID Number:
(410) 581-6600 ext. 3050[Phone]	FEIN Number: 52-0236900	

Filing Fees

Fee Required?	Yes
Fee Amount:	$125.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Baltimore Life Insurance Company	$125.00	04/19/2011	46731298

SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/21/2011	04/21/2011

SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
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Project Name/Number:	*APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY/8232-0411*		

Disposition

Disposition Date: 04/21/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
Filing Company:	*The Baltimore Life Insurance Company*	*State Tracking Number:*	*48532*
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Project Name/Number:	*APPLICATION FOR LIFE INSURANCE AND SINGLE PREMIUM ANNUITY/8232-0411*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	APPLICATION FOR LIFE INSURANCE AND SINBLE PREMIUM ANNUITY		Yes

SERFF Tracking Number:	*BALT-127119823*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: 8232-0411

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	8232-0411	Application/ Enrollment Form	APPLICATION FOR LIFE INSURANCE AND SINBLE PREMIUM ANNUITY	Initial		56.000	8232-0411.pdf

The Baltimore Life Insurance Company

10075 Red Run Boulevard • Owings Mills, MD 21117-4871 • 800.628.5433 • www.baltlife.com

Application for Life Insurance and Single Premium Annuity

1. Proposed Insured/Annuitant and Beneficiary Information

Last Name	First Name	MI

Social Security Number	Age	Sex	Date of Birth	State or Country of Birth	Height	Weight

Telephone: Day	Evening	Email Address

Street Address	City	State	ZIP Code

Drivers License Number	Drivers License State

Primary Beneficiary	Social Security Number	Relationship

Contingent Beneficiary	Social Security Number	Relationship

2. Owner *(if other than Proposed Insured)*

Last Name	First Name	MI	Relationship

Date of Birth	Tax ID# or Social Security#	Email Address

Street Address	City	State	ZIP Code

3. Contingent Owner

Last Name	First Name	MI	Relationship

Date of Birth	Tax ID# or Social Security#	Email Address

Street Address	City	State	ZIP Code

4. Single Premium Immediate Annuity with Period Certain

1. Payout Period (Predetermined by Annuitant's Issue Age): Age 60-74 / 10 Years Age 75-80 / 7 years

2. Estimated Single Premium $_____

☐ Non-Qualified Funds ☐ IRA *(Only Qualified Funds Eligible for IRA Rollover/ Transfer)*

3. Annuity Payout Payee:

All or a portion of each annual annuity payout from your Single Premium Immediate Annuity (SPIA) is considered taxable income to you depending on whether the source of funds is qualified or non-qualified. **If you elect tax withholding from each SPIA payout, the amount withheld will decrease the SPIA payout amount received by the payee. Using SPIA payouts to fund a life insurance policy, reduced by an amount withheld for tax, will decrease your life insurance death benefit. The amount withheld may change based on changing IRS and state requirements. You would be billed for any additional annual premium in full due on the life insurance policy. If the entire annual premium is not paid, your policy may lapse.**

Notice of Withholding and Election: I understand that if I elect not to have federal income tax withheld, I am liable for payments of federal and state income tax on the portion of my annuity distribution. I may also be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax and withholding, if any, are not adequate. I understand that if I do not complete the election below, the company is required to withhold federal and or state income tax on the taxable portion of my annuity distribution.

Your election will remain in effect until you revoke it. You may change your election each year.

(1) Check this box if you do not want any Federal income tax withheld from your annuity
☐ ***(If you check this box do not complete 2.)***

(2) I do want income tax withheld from my annuity payments. Federal: _____ State: _____

For questions regarding your election options, please consult with your personal tax advisor.

5. Insurance Product and Riders

Product	Estimated Face Amount: $

Accelerated Death Benefit Riders Included (if available) unless you check "No" here ___ No

1. Terminal Illness 2. Qualified Nursing Facility and Extended Care

Other Rider(s)

Nonforfeiture Options: ☐ Extended Term Insurance ☐ Reduced Paid-Up

Modal Premium: _____

6. Proposed Insured Medical Questions

Part A

1. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance? ..... ☐ Yes ☐ No
2. Have you ever:
   a. Been treated or hospitalized for insulin shock, diabetic coma, amputation due to diabetes, or have you taken insulin injections or by other methods prior to age 40 or been diagnosed with diabetes prior to age 25? ..... ☐ Yes ☐ No
   b. Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care? ..... ☐ Yes ☐ No
   c. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney (renal) insufficiency, chronic hepatitis, cirrhosis, liver disease, kidney or liver failure, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity? ..... ☐ Yes ☐ No
   d. Been medically treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? ..... ☐ Yes ☐ No
   e. Had more than one occurrence or any metastasis of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer or had an amputation caused by cancer? ..... ☐ Yes ☐ No
3. Within the past 12 months have you been confined three (3) or more times to a hospital, nursing facility, convalescent care facility or mental health facility? ..... ☐ Yes ☐ No
4. Within the past 24 months have you:
   a. Been declined or postponed for life or health insurance? ..... ☐ Yes ☐ No
   b. Been convicted of a felony or are you currently on probation or parole? ..... ☐ Yes ☐ No
   c. Been convicted of operating a vehicle while intoxicated or impaired? ..... ☐ Yes ☐ No
5. Within the past 24 months have you been diagnosed as having, been treated for, advised to have treatment for or hospitalized for:
   a. Angina, heart disease, heart attack, uncontrolled high blood pressure, heart or vascular surgery (including heart transplant, coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, stent placement or any procedure to improve circulation to the legs, heart or brain? ..... ☐ Yes ☐ No
   b. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities? ..... ☐ Yes ☐ No
6. Within the past 36 months have you been medically diagnosed, treated for or taken medication for:
   a. Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), attempted suicide, alcohol abuse or drug abuse? ..... ☐ Yes ☐ No
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, or required oxygen to assist in breathing? ..... ☐ Yes ☐ No

Part B

1. Are you taking medication for any impairment listed above? ☐ Yes ☐ No
2. Have you used any nicotine or tobacco based products in the past 12 months? ☐ Yes ☐ No
3. Have you applied for life insurance with any other insurance companies in the last two years? ☐ Yes ☐ No

Please provide details of all "Yes" answers from Section 6 in the area below.

Question #	Explanation	Dates/Duration	Name of Medical Professional

(Use Additional Comments section if more space is needed.)

7. Replacement Information

1) Does the proposed insured have any existing life insurance or annuities? ☐ Yes ☐ No
   If "Yes", policy status is: _____
2) Has the proposed insured had any policies lapsed or surrendered within the last six months? ☐ Yes ☐ No
3) Will this policy, if issued, replace or modify any existing life insurance or annuities in this or any other company? ☐ Yes ☐ No
   (This includes the use of dividends or other policy values.)
4) Is any other application for annuity or life insurance pending in this or any other company on the proposed insured? ☐ Yes ☐ No

Existing or Pending Insurance:

Name of Insured	Company	Policy Number	Amount $	Year Issued	Replace or modify?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

5) Why is this replacement occurring? _____

_____

8. Additional Ownership Information

1. Has any party to the application, such as the applicant, proposed insured, owner, if other than the applicant, or any beneficiary, entered or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the applied for policy? ☐ Yes ☐ No

2. Has any person promised or agreed to give or has given to any party to the application, or has any party to the application received or will receive from any person, any inducement, fee or compensation as an incentive to purchase the policy? ☐ Yes ☐ No

Please provide agreement details of all "Yes" answers in the Additional Comments section.

9. Additional Comments

_____

_____

_____

_____

_____

_____

_____

10. Declarations and Authorizations

It is understood that The Baltimore Life Insurance Company (the Company) has the right to require a medical examination. If so, this application is not complete until the medical examination has been performed.

AGREEMENT: I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I have read or had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

It is understood that the President, a Vice President, or the Secretary must sign all agreements made by the Company. No other person, including an insurance agent or broker, can change the terms of any policy or make any promise or agreement binding on the Company. Except as may be provided by the Conditional Receipt bearing the same date and form number as this application, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while each person proposed for coverage is alive and continues to be insurable, and whose condition of health and occupation, as described in this application, are unchanged from the date of the application.
2. The required premium is paid in full to The Baltimore Life Insurance Company, and the application is approved and accepted by the Company.

AUTHORIZATION AND ACKNOWLEDGMENT: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility or health care provider, insurance or reinsuring company, or MIB, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment, prescriptions and/or prognosis of me with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other nonmedical information about me to give to the Company any and all such information. I understand the information obtained by use of this authorization will be used by the Company to determine eligibility for insurance and/or benefits. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I acknowledge receipt of MIB, Inc.'s Pre-Notice and the Fair Credit Reporting Act Notice.

ACCELERATED DEATH BENEFIT TAX DISCLOSURE: The receipt of a benefit under an Accelerated Death Benefit Rider may be taxable. Before claiming benefits under these Riders, assistance should be sought from a personal tax advisor.

IMPORTANT TAX NOTICE FOR POLICYOWNER: Under federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

Certification: Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2) I am not subject to backup withholding under provisions of section 3406(a)(1)(c) of the Internal Revenue Code because a) I am exempt from backup withholding, or b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a US person (including a US resident alien).

The Internal Revenue Service does not require your consent to any provisions to this document other than the certification to avoid backup withholding.

I certify that I have read the medical questions contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

If replacement is occurring, please read the following notice: In many cases, the replacement of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement you are considering.

If you are replacing an existing policy and you are not satisfied with the new policy for any reason, you have the right to return your policy to us within 30 days after you receive it and receive a refund of all premiums paid.

Application made at _____ this _____ day of _____, _____
(City, State) (Day) (Month) (Year)

(X) _____ (X) _____
Signature of Proposed Insured Signature of Owner (If other than Proposed Insured)

(X) _____ _____
Signature of Licensed Agent (Witness to all signatures) *(Give official capacity if signed on behalf of a corporation, trust etc.)*

11. Agent Certification

I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification?..... ☐ Yes ☐ No

b. Do you have knowledge or reason to believe that replacement of existing life insurance or annuity policies may be involved?..... ☐ Yes ☐ No

c. If replacement is occurring, do you certify that this replacement complies with Baltimore Life's replacement guidelines? ..... ☐ Yes ☐ No ☐ Not Applicable

I certify that only advertising previously approved by The Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery. I am unaware of any additional information that might affect the Company's underwriting decision.

I certify that the above statements and responses are true and accurate.

_____ (X)_____

Print Agent's Name | Agent Number | Agent Signature | Date

Split Credit

If more than one agent is to receive split credit for this case, please complete the information below. Please Print.

Split Agent 2_____Agent No. _____%_____of split credits

Split Agent 3_____Agent No. _____%_____of split credits

Agent Comments

_____

_____

_____

_____

_____

_____

12. Conditional Receipt

(This receipt must not be detached unless the full initial premium is received at the time of application)

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY AND ACCEPTANCE UNLESS THE FOLLOWING CONDITIONS REQUIRED BY THIS RECEIPT ARE MET:

a. The full initial premium is paid according to the method of premium payment selected in the application for the amount of insurance applied for;
b. Any check given or draft authorized for premium payment is honored when first presented for payment;
c. All medical examinations, tests, X-rays and electrocardiograms required by the Company's underwriting rules and standards are completed within 60 days from the date of the application;
d. The Proposed Insured is, on the date of application and continuing until the policy is delivered, an insurable risk under the Company's rules, limits and standards as to plan, benefits, class, and amount for the policy applied for;
e. The application is approved by the Company; and
f. There is no material misrepresentation in the application or medical information furnished to the Company.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE PREMIUM PAYMENT. Subject to satisfactory completion of all of the above conditions, the effective date of coverage provided by receipt will be the later of: (1) the date of the application; (2) the date of the last of any medical examinations or tests required under the Company's underwriting rules and practices; or (3) the date, if any, requested in the application. Once coverage under this receipt becomes effective, the maximum death benefit and all other supplemental benefits provided by this receipt will be the lesser of: a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with the Company or b) $150,000. Either the Company or the proposed insured or owner, as applicable, may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application. If the Company declines to issue a policy or issues a policy other than as applied for which is not accepted, the premium payment will be refunded. There will be no liability on account of this receipt if any premium check or draft is not honored upon presentation for payment. If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment. If the proposed insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment. No broker, agent or medical examiner is authorized to accept risks or pass on insurability, make or alter any contract, waive a complete answer to any question in the application, waive any conditions under this receipt or waive any of the Company's rights or requirements or otherwise bind the Company in any way by any promise or statement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received $ _____ from _____ for an application on _____ Dated _____.

_____ _____

Signature of Proposed Insured Signature of Proposed Owner (If other than Proposed Insured)

_____

Signature of Agent

Tear here and leave notices below with Applicant

13. Fair Credit Reporting Act Notice

As part of our evaluation of your application for insurance, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

14. MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. The Baltimore Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure to you of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184-8734; the telephone number is (866) 692-6901.

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ar-read.pdf

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • P.O. Box 1060 • Owings Mills, Maryland 21117-5060
(410) 581-6600

CERTIFICATION OF READABILITY

This is to certify that Form 8232-0411 meets the minimum reading ease score for the state of Arkansas on the Flesch reading ease test.

Vice President _____ April 1, 2011
Date